CHAPTER 6 – Case Mix Accuracy Review (CMAR)

CMAR Overview

Residential Care Services (RCS) is responsible for monitoring the accuracy of the Minimum Data Set (MDS) data used to establish resident classification and payment of Medicaid rates. Within RCS, the Case Mix Accuracy Review (CMAR) unit is responsible to carry out a review process that is thorough and efficient in detecting errors in resident assessment data submitted for payment. The CMAR process is a method of assuring nursing facility payments or reimbursements are correctly matched to resident care needs. The MDS 3.0 resident assessment data forms the basis for the RUG-IV and/or other case mix model classification systems, which are factored into the payment rate. The case mix accuracy review process determines whether the MDS 3.0 data is accurate.

On-site stratified sample reviews of resident assessment data at each licensed and certified nursing home and desk audits accomplish RCS's monitoring responsibilities. The purpose of the accuracy review is to ensure that nursing facilities are submitting timely and accurate data of the resident's current functional status, clinical complexity, and co-morbidities. This data results in the correct Resource Utilization Group (RUG-IV) and/or other case-mix models. This review process serves to ensure the accuracy and efficacy of the MDS through problem identification and root cause identification.

Authority

- TITLE 42 C.F.R. §483.20 - RESIDENT ASSESSMENT
- RCW CHAPTER 74.46 – NURSING FACILITY MEDICAID PAYMENT SYSTEM
- CHAPTER 388-96 WAC – NURSING FACILITY MEDICAID PAYMENT SYSTEM
- CHAPTER 399-97 WAC – NURSING HOMES

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CHAPTER 6 – CMAR Index

Chapter 6 CMAR Overview

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6A – CMAR STANDARD OPERATING PROCEDURES

This section contains the Standard Operating Procedures that RCS staff are required to follow when conducting CMAR accuracy reviews.

CMAR STANDARD OPERATING PROCEDURES

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2. CMAR Background Information
3. CMAR Preparation for OnSite Visit
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6A1 – CMAR DEFINITIONS

A. DEFINITIONS

- "**Activities of Daily Living**" or "**ADL**" means those activities needed on a regular basis for self-care, such as: bathing, dressing, mobility, toileting, eating, transferring, or other related activities. This includes the "late-loss" ADLs (eating, toileting, bed mobility, and transferring), which are used to classify a resident into a RUG-IV group and/or other case-mix models.
- "**Administrative Sanctions**" means restrictions or obligations imposed by DSHS/RCS for violation of a set of internal regulations.
- "**Case Mix Accuracy Review**" or "**CMAR**" means the RCS unit that conducts the periodic nursing facility on-site accuracy review for MDS assessments of nursing facility residents. These reviews are for the purpose of verifying the accuracy of facility case mix data used to establish and update Medicaid payment rates and for other purposes, the department may deem appropriate.
- **"Default"** as used in the Washington State Medicaid Payment system, is actually referred to as 'default case' in RCW 74.46.020 (14).
- **"Default case"** means no initial assessment has been completed for a resident and transmitted to the department by the cut-off date, or an assessment is otherwise past due for the resident, under state and federal requirements.
- **"MDS Inaccuracy"** means that the during the on-site CMAR visit, the CMAR process found a MDS item that was coded incorrectly. The facility's coding is indicated as the Facility Value (FV) on the RUG Item Category Report. The MDS item is inaccurate and the documentation by the facility in the MDS cannot be substantiated. The FV can impact the assigned RUG or classification category and may decrease or increase the corresponding classification category.
- "**Minimum Data Set**" or "**MDS**" means a core set of screening, clinical assessment, and functional status elements, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid and for patients receiving SNF services in non-critical access hospitals with a swing bed agreement.
- "**Error**" means a change up or down in a resident's RUG-IV grouping and/or other case-mix models.
- "**Nursing Facility**" or "**NF**" means a nursing home, or any portion of a hospital, veterans' home, or residential habilitation center, that is certified to provide nursing services to Medicaid recipients under section 1919(a) of the federal Social Security Act. All beds in a nursing facility are certified to provide Medicaid services, even though one or more of the beds are also certified to provide Medicare skilled nursing facility services.
- "**Periodic CMAR Review**" means the regular on-site review conducted every 9 to 15 months by the CMAR unit.

- "**Quality Improvement Evaluation System**" or "**QIES**" means the federal umbrella administrative and computer system that encompasses the MDS and Swing Bed-MDS system, other systems for survey and certification, and home health providers.
- "**Resident Assessment Instrument**" or "**RAI**" means an assessment tool, which consists of three basic components: the MDS Version 3.0, the Care Area Assessment process and the RAI utilization guidelines.
- "**Resource Utilization Group**" or "**RUG**" means a category-based group model classification system in which nursing facility residents classify into RUG-IV and/or other case mix models rate groups based on their attributes as a recipient of NF services using a RUG or category worksheet. Residents in each group utilize similar quantities and patterns of resource. Assignment of a resident to a RUG-IV or other case mix model group is based on certain item responses on the MDS 3.0. WA State uses the RUG-IV 57 group model. Medicare Part A uses the 66 group model.
- "**Skilled Nursing Facility**" or "**SNF**" means a nursing home, a portion of a nursing home, or a long-term care wing or unit of a hospital that has been certified to provide nursing services to Medicare recipients under section 1819(a) of the federal Social Security Act.

B. QUALITY ASSURANCE REVIEW

1. Review this procedure for accuracy and compliance at least every two years.

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6A2 – CMAR BACKGROUND INFORMATION

A. Objectives of the CMAR Process:

- To provide each NF/SNF with ongoing education and information regarding inaccuracies found during the on-site review related to the items coded by the facility that placed the resident into the specific classification category.
- To provide each NF/SNF a clinical validation review to ensure an accurate Medicaid Rate is paid to all facilities.

B. Which Facilities are Reviewed During a CMAR Visit:

All Medicaid-certified NFs or dually-certified SNF/NFs in Washington State that are paid using the RUG-IV and / or other case mix model system must have a periodic on-site review by RCS to determine accuracy of the MDS 3.0 resident assessments. The expectation is that each Medicaid-certified facility will have an on-site case-mix accuracy review conducted every 9 to 15 months.

C. Unannounced Visits:

CMAR staff must conduct reviews that are unannounced and irregular/unexpected. Facilities are expected to create and implement systems that accurately assess residents at all times throughout the year. Unannounced visits help promote facilities to be accurate on a routine basis. The periodic on-site CMAR visit serves to validate assessment processes are occurring on a routine basis.

D. MDS Data Transmitted to QIES System and RUG Assignment and/or PDPM Scoring:

Assessments done through the RAI process are transmitted to the MDS database (QIES Assessment Submission and Processing) system according to Federal and State scheduling requirements. That data is run through a software instrument called a "Grouper" which analyzes the MDS coding responses and places each resident assessment into a case mix group. Each group has an assigned case mix weight and those weights contribute to the facility average case mix index, which provides the basis for the nursing portion of the daily Medicaid payment. A subset of MDS items are utilized and provide the basis for the grouper algorithm logic to place the resident's assessment into at least one of the 57 Resource Utilization groupings (RUGs) and/or PDPM score. It is paramount that those items affecting group determinations be accurate and verifiable.

E. QUALITY ASSURANCE REVIEW

1. Review this procedure for accuracy and compliance at least every two years.

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6A3 – CMAR PREPARATION FOR ON-SITE VISIT

BACKGROUND

Each Washington state Medicaid-certified facility will have an on-site review conducted on a periodic basis according to CHAPTER 388-96-905 WAC .

PROCEDURE

A. The CMAR Program Manager will:

1. Collaborate with the CMAR Nurse to prepare a schedule on a quarterly basis, which shows each facility within the state that requires an on-site review, and the date of the last review. This schedule ensures each facility is reviewed once every 9 to 15 months.

B. The CMAR Nurse must prepare for the CMAR visit by:

1. Determining when a facility will be visited in accordance with the frequency expectations. CMAR Nurses have some flexibility in determining the appropriate window between each of the CMAR on-site visits (e.g. which facilities can go 15 months or if a facility needs to have an earlier visit, etc.) Each CMAR Nurse should prepare an annual schedule identifying the calendar year quarter in which each facility will be reviewed.

2. Analyzing facility information for trends: Review the results of past on-site accuracy review visits and any recent survey citations or complaint investigations related to resident assessment for significant changes or trends.

3. Downloading the "RUG Item Category Reports" and/or other case mix model reports for the past 6-8 weeks using the CMAR portion of the QAN computer application and determine the anticipated sample size as detailed below. Select a sample based on the facility capacity and sample size of the previous year. The actual sample size will be finalized once the CMAR Nurse enters the facility and is given the facility's current census. Print out a few additional resident RUG and / or other case mix model item reports over and above the anticipated sample size, to account for discharges or for substitutions once on-site.

4. Using the following chart (see next page) to determine the appropriate sample size. The anticipated sample size will be determined using the facility capacity, while the final sample size will be determined on-site using the facility census on the first day of the visit. The sample is approximately 20% of the facility census.

Resident Census	Sample Size
1-4	All
5-10	5
11-20	8
21-40	10
41-44	11
45-48	12
49-52	13
53-56	14
57-75	15
76-80	16
81-85	17
86-90	18
91-95	19
96-100	20
101-105	21
106-110	22
111-115	23
116-160	24
161-166	25
167-173	26
174-180	27
181-186	28
187-193	29
194-299	30

5. Determining the stratified sampling according to the following methodology. The CMAR Nurse should select assessments that are not older than 70 days from the date of review, and preference is for those that have been completed as close to the on-site visit as possible. Typically, a sample selected from assessments completed within the last 6-8 weeks will provide enough candidates for review. This is intended to make it more likely that the resident is in the facility when the on-site review occurs. When determining the sample, the CMAR Nurse should use the RUG and / or other case mix model Categories Summary worksheet, and take the following factors into consideration:
   - Residents in the sample must include Title XIX (Medicaid), private pay, and Medicare residents.
   - At least one resident should be reviewed in each major RUG classification grouping present in the downloaded facility data.
   - Medicaid residents should be the largest sub-group of residents reviewed (they should be “over-sampled” when possible).

- Closed records may be included in the review. Proportionate to the populations identified in the RUG Category Summary worksheet, the rest of the sample may consist of residents in RUG groupings where areas of concern exist. These may be groupings with potential for gaming (i.e., Tracheotomies, Pneumonia, Septicemia, and Quadriplegia or others as appropriate), groupings that have demonstrated a high degree of coding errors or groupings that are clinically inconsistent with the facility's population.
- Do not review more than 3-4 residents in the Rehabilitation group. Because most residents that classify into the Rehabilitation group are Medicare residents, CMAR Nurses should avoid over sampling this population.
- Whenever possible, residents who have changed classification categories should be identified for review to determine the reason for the change.
- Residents with an assigned room number are more likely to be present in the facility when the on-site review occurs.

C. QUALITY ASSURANCE REVIEW

1. Review this procedure for accuracy and compliance at least every two years.

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6A4 – CMAR INITIAL REVIEW OF A NEW FACILITY

Purpose

To conduct an initial review in new SNFs/NFs to assure that the new facility is completing and submitting MDS assessments accurately.

A. Procedure

1. Each facility will have one unannounced visit after the first full quarter of MDS submissions has occurred. The sample size will be 50% of the normal CMAR sample size, except in facilities with 20 or fewer residents. In those cases, the sample size will be no less than five residents.

2. The CMAR Nurse will follow all of the regular CMAR processes under sections 6A1 through 6A7 of this chapter.

3. Findings from the review will be finalized for upload to the database to be used for rate setting purposes. Depending on the issues identified during the review, the CMAR Nurse may schedule a follow-up visit with a focus on the areas of concern identified during the pre-CMAR visit.

4. The first periodic CMAR review should occur 9 to 15 months after the date of certification for Medicaid.

B. Default Reports

1. Nursing home rates division sets facility Medicaid rates on a semi-annual schedule. In accordance with this schedule, the Case Mix Accuracy Review Program Manager will review final default reports twice a year and send an e-mail to each CMAR Nurse and Field Manager identifying which facilities had default payments above the acceptable threshold (more than 5 defaults in a final reporting period). The information will also include the names of the residents whose assessments were found to be in default status and the probable reasons for the defaults.

2. The CMAR Nurse will direct the facility to contact the MDS Automation Coordinator to find out what the facility needs to do to correct those defaults and to receive technical assistance to help identify potential systemic problems.

C. Potential Trends in a Facility

1. There are two areas, which should be verified during the next periodic review:
   - The case mix classification in a facility has shifted significantly within the facility; or

- The facility is submitting late assessments, or has a high error rate in submission. In order to verify default information, go to ALTSA Main Page, then select RCS, then select RCS Reports on the right side of the page, then select Home (on the web address), then select Case Mix, then select report 2506_CMUntimelyAssessmentDefaultSummary and then input the period for the report.

2. These default reports signify trends and may be investigated and addressed during a routine CMAR Nurse visit.

3. Trends may also signify that there is an emerging change in the functional level of facility residents. These changes could be caused by either physical or mental declines, illness or poor quality care, or admission of more residents with significant functional impairment. Any observed trend should alert the CMAR Nurse to potential problems, which could result in poor outcomes for residents, or increases in complaints. The CMAR Nurse should be aware of a facility's trends, and may confer with the MDS Automation Coordinator to discuss trends.

D. QUALITY ASSURANCE REVIEW

1. Review this procedure for accuracy and compliance at least every two years.

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6A5 – CMAR ONSITE VISIT PROCESS

A. Entrance Upon entering a facility, the CMAR Nurse will:

1. Meet with the facility's administrative staff to introduce themselves, explain the purpose of the visit and the expected progression of activities (such as record review, resident rounds, interviews with residents and staff and exit conference).

2. Answer any questions facility staff have and give the facility a copy of the CMAR entrance letter.

3. Obtain an updated resident roster, and any other materials/documents needed to conduct the review.

4. Request a place to work; and

5. Have facility administration identify staff who can serve as a resource in locating clinical information or documentation.

B. Review Process

1. One MDS 3.0 must be reviewed for each resident in the sample. The CMAR Nurse may need to review resident data sheets, flow sheets, and other documents used by facility staff to determine what is most relevant for validation of the resident's status and classification for the timeframe being reviewed.

2. The CMAR Nurse must, using clinical records, observation, and interview, verify that the MDS accurately represents the resident's condition during the assessment reference period, and is consistent with MDS 3.0 items, definitions, time frames and RAI Manual clarifications. The clinical record should also demonstrate evidence of the facility's assessment processes and the observed status of the resident should be supported in the clinical record. Items that cannot be validated must be documented on the work sheets (RUG-IV and / or other case mix model major category worksheets) in a bold font for easier identification of MDS inaccuracies.

3. Prior to completing the record review/data collection process for each sampled resident, the CMAR Nurse should recheck accuracy on all MDS 3.0 reimbursement items used for calculating the resident's major RUG and / or other case mix model grouping. A separate worksheet should be used for each MDS 3.0 reviewed. This does not mean that all RUG and / or other case mix model items are reviewed for each resident; the CMAR Nurses should focus on the accuracy of the items that place the assessment into the assigned RUG-IV and / or other case mix model

grouping (refer to CMAR worksheets). If it appears that the facility has a number of accuracy problems with MDS assessments, the CMAR nurse may consider doing a future protocol visit to follow-up on the identified issues even though the facility's RUG error rate was less than 30%.

4. If MDS inaccuracies are found during record review that are not part of the category being reviewed, the CMAR nurse will list those MDS inaccuracies on the CMAR REVIEW SUMMARY FOR MDS 3.0 and those MDS inaccuracies will be included in the count of MDS inaccuracies. If there is a pattern of MDS inaccuracies that impact resident care planning, the CMAR nurse will consult with the CMAR Program Manager and then consult with the appropriate RCS Nursing Home Field Manager before making a report to CRU for investigation of MDS inaccuracy. The report will include the specifics of the allegation.

C. Record Review

1. The purpose of the record review is to verify the clinical and functional status of the resident in the record during the assessment reference period of the MDS in review.

2. The facility is responsible for maintaining records and for making these records available to appropriate State and Federal personnel. The CMAR Nurse must attempt to validate the MDS with corroborating information from the medical record. However, the resident interview items which record the resident's response to scripted questions right on the MDS do not require other information to validate or verify the resident's answers.

3. The MDS 3.0 must accurately represent the resident's clinical conditions during the assessment reference period. Although the entire assessment must be accurate, as stated in federal regulations (42 CFR 483.20), Case-Mix reimbursement items are the focus of this review. Information from the entire record may be considered in verification of the assessment.

4. The CMAR Nurse must verify ADL status for each resident chosen for review, using the ADL index work sheet.

D. Staff Interviews

1. The CMAR Nurse may conduct interviews with facility staff members as part of the accuracy review process. If possible, the CMAR Nurse should interview staff persons from different shifts to obtain information about the resident's level of functioning at different times of the day, evening, or night. Discrepancies in verbal

information and documentation that are pertinent to the RUG and/or case mix model category should be noted on the appropriate worksheet.

E. Resident Interviews/Observations

1. The CMAR Nurse should observe some of the residents in the sample, and interview residents and families when appropriate. Resident observations that are pertinent to the RUG and/or other case mix model category, including time and date of observation, should be documented on the individual resident worksheets.

2. The CMAR Nurse should strive to gain as complete a picture as possible of the resident's current physical and mental condition and abilities, needed treatments and medications, services and interventions provided by staff and daily life activities in order to verify the assessment items.

3. Resident ADLs are some of the more relevant and important observations and should be made by the CMAR Nurse whenever possible. Remember however, that what you observe while on-site may not reflect what the resident's condition was at the time the MDS was completed. Follow-up any observations with interviews of residents, family, and/or facility staff when needed.

4. When it is necessary to observe a wound, pressure ulcer, gastrostomy site, or other similar situation, the CMAR Nurse will ask facility staff to accompany them to view the area in question and, **with permission from the resident**, to arrange the resident's bed linen, clothing, wound dressing, as necessary to observe.

F. Data Reconciliation

1. The CMAR Nurse must compare the classification data on the "RUG Item Category Reports" and/or other case mix model reports with the observations, interviews, and documentation in the record, including the MDS 3.0 assessment that was used to classify the resident. The CMAR Nurse will review the resident's medical records and if any items are determined to be different from the "FV" or Facility Value column, record those findings under the "QV" or QAN Value column on the RUG and/or other case mix model item report.

2. Discrepancies must be noted on the worksheets, and should contain sufficient supporting detail, including copies of care plans, doctor's notes, copies of medical records or other appropriate records.

3. Using multiple sources of record information, validate the RUG and/or other case mix model items for the resident. Conduct resident, family, and staff interviews as well as resident observations as needed.

4. The CMAR Nurse must gather and record data such that during the Informal Administrative Appeal process, the Case-Mix Accuracy Review Program Manager is able to determine what specific issues led to the reviewer's findings and decision-making.

5. When a discrepancy is identified, the reviewer will interview the appropriate facility representative to provide additional clarifying information. If items cannot be clarified and consensus reached about an assessment item(s), further discussion may occur at the exit conference.

6. The CMAR Nurse will document findings and conclusions on the appropriate forms and worksheets, and based on the CMAR Nurse's findings a new resident case-mix classification (RUG, and/or other case mix model) may be determined. MDS item changes (MDS Inaccuracies) will be entered into the CMAR portion of the QAN application computer program and a new RUG classification may result based on those changes.

G. Questions the CMAR Nurse should ask themselves during the on-site review

- Has there has been a significant change in RUG and/or other case mix model groupings, have resident care needs changed?

- Have there been staff changes in who is performing the MDS assessments? Have there been system changes in the facility?

- Do the changes reflect changes in the facility accuracy in documentation and assessment since the last CMAR visit and signify the facility is more/less accurately coding and assessing residents?

H. Documentation of CMAR Findings

1. On the CMAR Review Summary Report, use a bold font for those rows where there are RUG and/or other case mix model changes and MDS Inaccuracies.

2. On all RUG and/or other case mix model Worksheets, complete the Assessment Reference Date (A2300), Admit/Readmit Date (1600) and "Day 7" fields.

I. Criteria for RUG and/or other case mix model Error Rate

1. If the resident's major RUG and/or other case mix model classification group (i.e., from Special Care Low to Clinically Complex) changes as a result of the case mix accuracy review, the CMAR nurse must review the new RUG and/or other case mix model with its corresponding worksheet to validate that all documentation for that RUG and/or other case mix model is present in the clinical record.

2. If the clinical record does not have documentation to validate the new RUG and/or other case mix model, then the resident will be grouped into the next corresponding RUG and/or other case mix model group. This will count as two MDS inaccuracies and one RUG and/or other case mix model change for the Case Mix Accuracy Review Summary Report.

3. Any MDS item reviewed and not verified must be reported to the facility on the CMAR Review Summary for MDS 3.0. However, not all of the inaccuracies result in a change up or down in a resident's RUG-IV and/or other case mix model grouping.

J. <u>Determining the RUG and/or other Case Mix Model Error Rate – (See Table on next page)</u>

1. Look at the far left column and find the sample size, which was reviewed.

2. Move across the top row and find the number of errors (the number of RUG Categories and/or other case mix models that changed). Remember if a resident's RUG changes MDS, it is only counted as one RUG change.

3. Move across the column and row and find the box where they intersect. This is the error rate for the sample that was reviewed.

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Determining an Error Rate for Case Mix Accuracy Review

- Look at the far left column and find the sample size, which was reviewed.
- Move across the top row and find the number of errors (the number of RUG and/or other case mix models Categories that changed from the information sent by the facility).
- Move across the column and row and find the box where they dissect. This is the error rate for the sample that was reviewed.

# of Errors	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Sample Size																
1-4	100%	100%	100%	100%												
5	20%	40%	60%	80%	100%											
8	12.5%	25%	37.5%	50%	62.5%	75%	87.5%	100%								
10	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%						
11	9.1%	18.2%	27.3%	36.4%	45.5%	54.6%	63.6%	72.7%	81.8%	90.9%	100%					
12	8.3%	16.7%	25%	33.3%	41.7%	50%	58.3%	66.7%	75%	83.3%	91.7%	100%				
13	7.7%	15.4%	23.1%	30.8%	38.5%	46.2%	53.8%	61.5%	69.2%	76.9%	84.6%	92.3%	100%			
14	7.1%	14.3%	21.4%	28.6%	35.7%	42.9%	50%	57.1%	64.3%	71.4%	78.6%	85.7%	92.9%	100%		
15	6.7%	13.3%	20%	26.7%	33.3%	40%	46.7%	53.3%	60%	66.7%	73.3%	80%	86.7%	93.3%	100%	
16	6.3%	12.5%	18.8%	25%	31.3%	37.5%	43.8%	50%	56.3%	62.5%	68.8%	75%	81.3%	87.5%	93.8%	100%
17	5.9%	11.8%	17.6%	23.5%	29.4%	35.3%	41.2%	47.1%	52.9%	58.8%	64.7%	70.6%	76.5%	82.4%	88.2%	94.1%
18	5.6%	11.1%	16.7%	22.2%	27.8%	33.4%	38.9%	44.4%	50%	55.6%	61.1%	66.7%	72.2%	77.8%	83.3%	88.9%
19	5.3%	10.5%	15.8%	21.1%	26.3%	31.6%	36.8%	42.1%	47.4%	52.6%	57.9%	63.2%	68.4%	73.7%	78.9%	84.2%
20	5.0%	10%	15%	20%	25%	30%	35%	40%	45%	50.0%	55%	60%	65%	70%	75%	80%
21	4.8%	9.5%	14.3%	19%	23.8%	28.6%	33.3%	38.1%	42.9%	47.6%	52.4%	57.1%	61.9%	66.7%	71.4%	76.2%
22	4.5%	9.1%	13.6%	18.2%	22.7%	27.3%	31.8%	36.4%	40.9%	45.5%	50%	54.5%	59.1%	63.6%	68.2%	72.7%
23	4.3%	8.7%	13%	17.4%	21.7%	26.1%	30.4%	34.8%	39.1%	43.5%	47.8%	52.2%	56.5%	60.9%	65.2%	69.6%
24	4.2%	8.3%	12.5%	16.7%	20.8%	25%	29.2%	33.3%	37.5%	41.7%	45.8%	50%	54.2%	58.3%	62.5%	66.7%
25	4.0%	8.0%	12%	16%	20%	24%	28%	32%	36%	40.0%	44%	48%	52%	56%	60%	64%
26	3.8%	7.7%	11.5%	15.4%	19.2%	23.1%	26.9%	30.8%	34.6%	38.5%	42.3%	46.2%	50%	53.8%	57.7%	61.5%
27	3.7%	7.4%	11.1%	14.8%	18.5%	22.2%	25.9%	29.6%	33.3%	37.0%	40.7%	44.4%	48.1%	51.9%	55.6%	59.3%
28	3.6%	7.1%	10.7%	14.3%	17.9%	21.4%	25%	28.6%	32.1%	35.7%	39.3%	42.9%	46.4%	50%	53.6%	57.1%
29	3.4%	6.9%	10.3%	13.8%	17.2%	20.7%	24.1%	27.6%	31%	34.5%	37.3%	41.4%	44.8%	48.3%	51.7%	55.2%
30	3.3%	6.7%	10%	13.3%	16.7%	20%	23.3%	26.7%	30%	33.3%	36.7%	40%	43.3%	46.7%	50%	53.3%

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# of Errors	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Sample Size														
1-4														
5														
8														
10														
11														
12														
13														
14														
15														
16														
17	100%													
18	94.4%	100%												
19	89.5%	94.7%	100%											
20	85%	90%	95%	100%										
21	81%	85%	90.5%	95.2%	100%									
22	77.3%	81.8%	86.4%	90.9%	95.5%	100%								
23	73.9%	78.3%	82.6%	87%	91.3%	95.7%	100%							
24	70.8%	75%	79.2%	84%	87.5%	91.7%	95.8%	100%						
25	68%	72%	76%	83.3%	84%	88%	92%	96%	100%					
26	65.4%	69.2%	73.1%	80%	80.8%	84.6%	88.5%	92.3%	96.2%	100%				
27	63%	66.7%	70.4%	76.9%	77.8%	81.5%	85.2%	88.9%	92.6%	96.3%	100%			
28	60.7%	64.3%	67.9%	74.1%	75%	78.6%	82.1%	85.7%	89.3%	92.9%	96.4%	100%		
29	58.6%	62.1%	65.5%	71.4%	72.4%	75.9%	79.3%	82.8%	86.2%	89.7%	93.1%	96.6%	100%	
30	56.7%	60%	63.3%	69%	70%	73.3%	76.7%	80%	83.3%	86.7%	90%	93.3%	97.7%	100%

K. Exit Conference

1. The CMAR Nurse must conclude all on-site reviews with an exit conference with facility administration. The purpose of an exit conference is to provide facility staff with the review findings and attempt to resolve differences in the coding of MDS 3.0 payment items and subsequent case-mix classification of resident assessments. The facility administration should attempt to resolve discrepancies prior to or during the exit conference.

2. The CMAR Nurse should inform facility administrative staff of the exit conference time as early in the process as possible to help ensure they can attend. The CMAR Nurse and any additional RCS staff involved in the CMAR review should attend the exit conference.

3. During the exit conference, the CMAR Nurse will:
   - Make introductions;
   - Express appreciation for facility staff assistance during the visit;
   - Restate the reason the on-site visit was conducted;
   - Explain the exit conference; and
   - Share the findings from the review, including:
     - The number of residents in the sample;
     - The MDS inaccuracies identified by the reviewers;
     - A description of the information which substantiates the MDS inaccuracies;
     - The facility's coding; and
     - Any changes in the resident's RUG-IV classification and the projected error rate caused by the MDS inaccuracies.

4. The discrepancies in RUG and/or other case mix model items must be presented in a polite, objective, and non-judgmental manner. It is important for RCS staff to differentiate between incorrect clinical logic and logic, which is different, but based in supporting nursing literature. Successful two-way communication is a key element in validation and education of facility staff. The facility should be given a copy of the "CMAR Review Summary".

5. The facility should be notified if the findings are being referred to the CMAR Program Manager for possible further action.

6. Information about the findings of the CMAR Nurse presented during the exit conference are to be considered as final, **unless** the CMAR Nurse tells the facility that the report is a preliminary report and that they will be sending the facility a final CMAR review MDS Summary for MDS 3.0 report. The facility should be advised that after the exit conference no additional documentation will be accepted, except those submitted as part of an appeal or informal administrative hearing. A nursing facility representative must sign page one of

the CMAR Review Summary report to indicate that an exit conference was held and that they have received a copy of the report.

L. Dear Administrator Letter and CMAR Review Summary Report

1. The CMAR Nurse will usually give the facility a "Dear Administrator" letter during the exit conference along with the CMAR Review Summary for MDS 3.0 Report. The "Dear Administrator" letter lists the results of the MDS Accuracy Review, and describes the appeal process. This formal notice letter to the facility will specifically state:
   - Which resident assessments were reviewed;
   - What RUG-IV and/or other case mix model grouping was determined for the residents reviewed;
   - What changes in assigned classification will occur for the MDS inaccuracies found;
   - What the resultant error rate was at the completion of the review;
   - What the rights of the facility are to appeal the CMAR findings through one opportunity for an informal administrative hearing;
   - Where to send the appeal request if mailed or if emailed, including a reminder that if the appeal request has any resident identifying information that the appeal request must be encrypted; and
   - The time limit of ten (10) calendar days for requesting the appeal, as provided under WAC 388-96-905(5).

2. If the CMAR Nurse does not give the facility the two documents described above at the exit conference, or if after further review, the RUG-IV grouping and/or other case-mix models for any resident is changed after the exit conference, then the CMAR Nurse will fax or email the nursing home administrator a final version of these two documents within 5 working days of the exit conference, not including the date of the exit conference.

- **Communicating Results of the Informal Administrative Appeal**
  1. The CMAR Program Manager will conduct the appeal process and rule on the resident specific findings. The results of that determination will be entered into the database and used for rate setting. The facility, the CMAR Nurse, the Regional Administrator, and the Field Manager will be notified of the outcome of the process.
- **QUALITY ASSURANCE REVIEW**
  1. Review this procedure for accuracy and compliance at least every two years.

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6A6 – CMAR POST VISIT PROCESS

Process

If quality of care problems and/or significant numbers of inaccurate assessments of residents were noted during the on-site visit, a report addressing these findings should be submitted to the Field Manager for review and possible action. A copy of the "CMAR Report to Survey" will be emailed to the Field Manager and a copy will be sent with facility's CMAR papers to the Case Mix Accuracy Review Program.

A. Finalization of Accuracy Review Reports

1. After completing the MDS on-site review, the CMAR Nurse should review all data for accuracy and completeness. This is a paper-only process.

2. On the RUG Item Report form and/or other case-mix model form, circle the MDS item coding values that are suspected to be in error in the FV column and then select the correct value and circle it in the QV column. Initial and date the last page of the report.

3. Be sure RUG and/or other case-mix models Classification Worksheets are signed and dated.

4. Send the completed packet of original CMAR work papers, including:
   - CMAR Work papers Check Off List
   - CMAR category worksheets
   - Facility's additional documentation
   - Dear Provider Letter reviewing the final results of the CMAR visit
   - CMAR REVIEW SUMMARY FOR MDS 3.0 report,
   - CMAR Report to RCS Nursing Home Field Offices reports to the Case Mix Accuracy Review Program Manager at ALTSA headquarters for review
   - Placement into the case-mix master file

5. The field office cubicles of the CMAR Nurses will not store any CMAR facility work papers. All CMAR Nurses will be able to access previous CMAR work papers via DSHS' Records Management Tool.

B. Finalization of Accuracy Review Reports (Computer Process)

1. Changes that a CMAR Nurse finds in the resident assessment during case mix accuracy review will be entered into the CMAR portion of the QAN application

computer program, which is accessed by ALTSA rates division for use in calculating facility payment. These changes **may** result in a change in the resident's case-mix grouping and case-mix weight, which in turn **may** change (a) the facility's average case-mix index, and (b) the Medicaid average case-mix index. These values are used to set the facility's rate.

2. The CMAR nurse will enter all MDS inaccuracies into the CMAR edit portion of the QAN application computer program during the on-site visit, and verify if a change to the RUG-IV classification and/or other case-mix models has occurred.

3. Once all MDS items are entered for a particular resident's assessment, the changes should be marked for upload to enable transmission back to the RCS database.

C. QUALITY ASSURANCE REVIEW

1. Review this procedure for accuracy and compliance at least every two years.

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6A7 – CMAR SANCTIONS AND REPORTING INACCURACIES TO CRU

Purpose

The Minimum Data Set (MDS) is a tool for assessment of residents. CMAR Nurses monitor the accuracy of resident assessment data through the formalized Case Mix Accuracy Review (CMAR), which was instituted in 1998. CMAR error rates reflect the accuracy rate of the coding of the MDS items that are part of the RUG-IV system and/or other case-mix models.

Process

A. Phase 1 Sanction

1. If at the conclusion of the on-site CMAR visit, the CMAR Nurse determines the RUG and/or other case-mix model error rate to be greater than 30%, the facility is now considered to be in Phase I sanction and must complete a return focused visit within 12 weeks. The CMAR Nurse must notify the CMAR Program Manager of this error rate.

B. Return Focused Visit

1. The CMAR Nurse must do a focused visit to the facility within 12 weeks to determine what potential assessment system problems may be present that may have contributed to the high error rate. The CMAR Nurse may **choose one** of the following methods for a "Return Focused Visit" depending on the areas which had the most MDS inaccuracies:

   - **Focused Review of RUG and/or other case-mix models Categories:**
     To do a focused review in the RUG-IV and/or other case-mix models categories that had high errors using the corresponding worksheets. The sample size will be from five to seven residents and will based on the facility's census.

Residents	Sample Size
1 – 75	5
76 – 110	6
111 – 299	7

- **Quality Assurance Protocol Visit:** To do a sample review using the quality assurance protocol. The sample size will be from five to seven residents and will be based on the facility's census.

Residents	Sample Size
1 – 75	5
76 – 110	6
111– 299	7

2. The CMAR work papers that are completed will be determined by the method the CMAR nurse uses for the return focused visit. The CMAR work papers are described below:
    a. Focused Review of RUG and/or other case-mix models Categories:
        i. The CMAR nurse will complete the appropriate category worksheets for each category reviewed and include the worksheets and any corresponding copies of additional information in the CMAR work papers sent to the CMAR Program Manager.
        ii. The CMAR nurse will complete the CMAR REVIEW SUMMARY FOR MDS 3.0 report and have it signed by the facility. The facility will be given a copy of the signed report and will include the report in the CMAR work papers sent to the CMAR Program Manager
    b. Quality Assurance Protocol Visit:
        i. The CMAR nurse will complete a Protocol in the QAN program for each resident in the sample.
        ii. The Protocol work papers will be given to the facility and a copy will be sent to the CMAR Program Manager.

    At the conclusion of the focused visit, the CMAR Nurse should notify the CMAR Program Manager of the findings and send the complete packet of worksheets and reports to the CMAR Program Manager at ALTSA headquarters.

C. <u>Phase 2 Sanction</u>

1. Any facility in Phase I sanctions that has an error rate equal to or greater than 30% at the next periodic CMAR visit (within the next 9 to 15 months), will move into the second phase of sanction activity (Phase 2), which includes the following:
    - The CMAR Nurse must complete another return focused visit in accordance with the same procedures under subsection 1 of this section.

- The Case Mix Accuracy Review Program Manager, after consultation with the appropriate Field manager will have the CMAR Nurse make a report to CRU for investigation of MDS inaccuracy. The report will include the specifics of the allegation.

D. QUALITY ASSURANCE REVIEW

1. Review this procedure for accuracy and compliance at least every two years.

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6B – CMAR INFORMAL APPEALS PROCESS

Overview

Nursing Facilities shall be provided an opportunity to appeal the Case Mix Accuracy Review (CMAR) findings. The facility may request an appeal within ten (10) calendar days from the end of the CMAR visit. This request must be timely (10 calendar days) from the end of the CMAR visit in order for the request for an informal administrative hear to be considered.

A. Procedure

1. The Case Mix Accuracy Review Program Manager will review any documentation information submitted with the request, and contact the provider to clarify the type of review the provider would like to have including: face to face; telephone conference; record review; or any combination of these.

2. The Case Mix Accuracy Review Program Manager will schedule the informal hearing as soon as possible after the provider request for a mutually agreeable date.

3. Any supporting documentation or other information from the facility must be submitted to the Case Mix Accuracy Review Program manager on or before the informal administrative hearing date.

4. The Case Mix Accuracy Review Program Manager will send the appeal decision in writing to the nursing facility administrator within 10 working days after the informal administrative hearing or within 10 working days after receipt of any additional information or documentation requested, whichever is later.

5. The Case Mix Accuracy Review Program Manager will not be involved in preliminary decisions related to the case mix findings prior to the informal hearing.

B. The Informal Case Mix Accuracy Review Hearing

1. Face-to-face or telephone hearings should last no longer than one hour.

2. The purpose of the informal hearing is to give the provider one opportunity to present documentation and information that might warrant modification or

deletion of resident-specific accuracy findings resulting from the case mix accuracy review.

3. The hearing will focus only on clinical issues of resident need and assessment.

4. On or before the hearing, the provider must submit the supporting documentation or other information to the Case Mix Accuracy Review Program Manager. Additional information may be requested by the Case Mix Accuracy Review Program Manager at any time prior to the final informal hearing decisions being issued.

5. At the conclusion of the informal hearing, the Case Mix Accuracy Review Program Manager will review the issues and remind the provider when and how the decisions will be made.

C. Decision Making/Results

1. The Case Mix Accuracy Review Program Manager has 10 working days after the informal hearing or within days of receiving any additional information, whichever is later, to make a decision and notify the provider of the results.

2. The determination will either uphold the facility coding of the MDS (minimum data set) or support the Case Mix Accuracy Review findings of an MDS item inaccuracy.
   a. If the hearing uphold the facility's MDS coding, the Case Mix Accuracy Review Program Manager will revise the Case Mix Accuracy Review forms, the summary report, and the QAN database to reflect the changes.
   b. If the Case Mix Accuracy Review Nurse's findings are supported, the Case Mix Accuracy Review forms, the summary report, and the data in the QAN database will remain as they were at the completion of the case mix accuracy review.

3. The results of the informal hearing will be sent to the provider in writing via regular mail.
   a. These results represent the final agency decision by the department.
   b. If the provider is dissatisfied with the final agency decision, a petition for judicial review may be requested under the state's Administrative Procedure Act (chapter 34.05 RCW).

c. A copy of the informal hearing results will be sent to the appropriate field manager.
d. A copy of the results, along with all materials used in the informal administrative hearing, will be retained in the facility case mix file at DSHS/RCS headquarters office in Lacey.

D. QUALITY ASSURANCE REVIEW

1. Review this procedure for accuracy and compliance at least every two years.

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APPENDIX A – RESOURCES AND FORMS

A. RESOURCES AND FORMS

1. CMAR Entrance Letter
2. CMAR Worksheets:
    a. ADL Index Score Calculation
    b. PDPM Nursing component: ADL Function Score Calculation
    c. Rehabilitation
    d. Extensive Services
    e. Special Care High
    f. Special Care Low
    g. Clinically Complex
    h. Behavioral Symptoms & Cognitive Performance
    i. Reduced Physical Function
    j. Therapies and Enteral/Parenteral Work Sheet for CMAR
3. CMAR Review Summary for MDS 3.0 (given at Exit Conference by CMAR Nurse)
    a. CMAR Review Summary - Additional
4. CMAR Dear Administrator Letter (given at Exit Conference by CMAR Nurse)
5. CMAR Work Papers Check Off
6. CMAR Application Workbook
7. CMAR Report to RCS Nursing Home Field Offices

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CHAPTER 6 – CASE MIX ACCURACY REVIEW CHANGE LOG

EFFECTIVE DATE	CHAPTER SECT #	WHAT CHANGED? BRIEF DESCRIPTION	REASON FOR CHANGE?	COMMUNICATION &TRAINING PLAN
9/20/2019	**Chapter 6 All Sections**	All available SOPs, (OPPs) forms & resources are captured in a formal RCS Chapter format	To ensure all staff are familiar with all processes. To comply with Director mandate.	MB, SOP R19-068

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